Draft Health Reform Plan Roadmap

1. Goals for June 20th KHPA Board Meeting

- Review demographics of Kansas uninsured
- Review of 2005 Mercer health insurance study (in reference section)
- Determine overarching health reform goals
- Review health reform priorities for 2008 to 2012
- Consider health insurance reform design
- Plans to complete health reform grid/Assign policy questions to Advisory Councils

2. Kansas uninsured demographics

- **Major points:**
  - Most Kansans who are uninsured work for small businesses with less than 50 employees (77.2%); many work for very small businesses with less than 25 employees (66.3%).
  - The vast majority (95%) of uninsured Kansans live in families with someone who is employed.
  - Most uninsured Kansans are low income; 56.6% of them make less than 150% of the federal poverty level (FPL).
  - Most Kansas without health insurance have been without it for over a year (67%).
  - Some areas of the state have higher rates of uninsured – for example, 16.8% of Kansans who live in southwest Kansas are uninsured.
- **Mercer study 2005**:
  - Excellent summary of health insurance information on Kansas
  - Very useful to help determine health plan design considerations
  - Used to develop the Business Health Partnership plan

3. Determine overarching health reform goals

Achieving Health for all Kansans – defining "all"

DETERMINING COVERAGE GOALS: This is the area that will get the most attention, may be the biggest cost driver, and is most likely to generate contention. Two possible goals are suggested: Universal coverage and Affordable coverage for all. Using Dr. Len Nichols' biblical analogy, "universal coverage" is "everyone SEATED at the table", whereas "affordable coverage for all" is "everyone INVITED to the table, but not necessarily seated." Each goal will almost certainly lead to different requirements in developing the options to get us there.

UNIVERSAL COVERAGE: This definition does not necessarily imply 100% coverage of all legal Kansas residents. Instead, universal coverage may be defined as 95% or 96% coverage given certain exemptions for religious purposes, for people recently moved to the State. If universal coverage is attempted by requiring individuals to purchase health insurance and is managed through the income tax system (as in Massachusetts), it may be difficult to reach those who do not file taxes. Thus, some Kansans may take the "penalty" rather than the insurance. Attainment of even 96% coverage is significant and may require some form of "individual mandate."

AFFORDABLE COVERAGE FOR ALL: This approach entails making sure that all legal Kansas residents have access to a health plan that they can afford, but does not require them to purchase health insurance. If this approach is pursued, there should be goals to measure success based on decreasing the number of uninsured and research conducted to determine barriers to the purchase of health insurance. If these goals are not achieved within a set timeframe, the state could consider requiring individuals to have health insurance.

4. Review health reform priorities: 2008- 2012

A. Reform framed around three draft "messages"

- Providing and protecting affordable health insurance
  - Health insurance reforms, as framed by SB 11
    - Health connector
    - Reinsurance
    - Consumer driven care
    - Premium assistance/subsidies for low income
- Paying for prevention and primary care
  - Focused on health outcomes and health care cost savings
  - Implementing tobacco control plan
  - Managing obesity and related health conditions
- Promoting personal responsibility
  - Improving personal health behaviors
  - Incentivizing healthy communities
  - Paying for health insurance on a sliding scale based on ability to pay

B. **TIMELINE:** Assuming enactment of related legislation in early 2008 ***and*** assuming the implementation requirements are not overly complex ***and*** assuming adequate funding is provided, ***full*** implementation by the end of FY 2012 is both a reasonable and an ambitious goal.

- **Phasing in reforms**: Developing logical plan to phase in certain populations, such as coverage of all children and/or coverage of the working poor within 3 years (the end of FY 2010)
- **Financing:** Identifying financing options is a requirement of SB 11. Financing can include an increase in tobacco tax commensurate with the

associated costs with tobacco related diseases (a health assessment fees) and as well as other types of health assessments, drawing down additional federal dollars through Medicaid reforms; and increased state, individual and employer contributions.

5. Consider health insurance reform designs

BENEFIT PLAN

A key factor will be defining a "minimum creditable benefit plan" since this will not only be a major determinant of costs, but also a critical success factor in assuring the affordability of health care (co-insurance, deductible, co-pays). While the State employee health plan may be a good starting point for comparative purposes, we may need to explore several options as part of the modeling process.

AFFORDABILITY

A commonly accepted measure for determining the affordability of health insurance is that the premium for "creditable coverage" should not exceed a certain percent of gross family income, such as 8 - 12%. The exception to this is families and individuals falling below a certain income level (e.g., 100% FPL) who generally need assistance with the premium and co-insurance.

ASSISTING SMALL BUSINESSES

Given the breakdown of the current uninsured population in Kansas, any meaningful reduction in this population will have to address ways of increasing access to coverage for people working for small businesses (less than 25 or 50 employees). Two themes are common in state reform efforts.

First, a number of states provide subsidies to low income uninsured residents coupled with private sector health insurance reforms. Some states have combined the state/federal subsidies together with health insurance exchange/connector models. When providing subsidies to employers, states must consider whether to limit participation to those businesses that have not offered coverage to their employees in the past. This serves as a means of controlling subsidy costs. Kansas will need to decide if we want to limit incentives to those small businesses that have not previously offered coverage, or open it up to all small businesses. Other states have successfully used reinsurance (New York) to help stabilize the health insurance market and make health insurance more affordable.

Second is the issue of mandates. Many health reform experts consider an individual mandate combined with some form of employer mandate or assessment to be a requirement in order to achieve universal coverage – depending on the state's definition of "universal."

SUSTAINABILITY

The cost of health insurance reforms will generally be a shared responsibility between the enrollees, employers and the government (state and federal). In addition to the

affordability issue referenced above for enrollees, reform proposals should also be affordable to employers and the government.

For employers, one measure of affordability would involve employers currently providing creditable coverage to determine what they currently pay for insurance. Health reform options could then be designed that maintain or reduce this contribution level.

For the state contribution, there are two considerations. First is identifying either savings in existing programs or new revenue sources to cover any new expenses to the maximum extent possible. Second is to provide some form of dedicated funding in order to avoid the variation in annual budget cycles. It will be critical in designing health reform options to model expected costs for individuals, employers, and state/federal government as well as an estimate of how many Kansans will gain access to affordable health insurance as a result of the reforms.

KEEP IT SIMPLE

Learning lessons from the complexity of Medicare Part D, reform options should be simple to explain to the public, simple for employers and simple for enrollees. Health plans should be designed so that related interfaces are simple for plan participants. The development of these plans will require adequate lead time for proper implementation and there must be adequate staffing/budget to operate the programs. Both should be clearly identified as part of the proposal. The Board should consider limiting the number of health reform options to present to the Governor and legislature.

6. Plans to complete health reform grid/Assign policy questions to Advisory Councils: Draft questions

Benefits package:

- What benefits are considered crucial in a health insurance plan (drug coverage, dental, mental, etc.)?
- Which benefits should be dropped if we need to for cost considerations?

Small Business:

- Should we limit incentives to small businesses that have not previously offered coverage, or open it up to all small businesses?
- What are the most critical issues to small businesses in terms of providing health insurance?

Employer responsibility:

- Should employers be required to contribute to achieve health for all? Which employers?
- Should very small employers be carved out and not required to participate?

Individual responsibility:

- What constitutes an affordable plan?
- How much should the individual pay?

Health Insurance Connector

- What are the pros and cons of health insurance connector?

- Should the connector be voluntary or mandatory? For only small business or open to all interested businesses?

Mandates

- Should all Kansans be required to have health insurance?
- Should all businesses be required to provide health insurance or pay some assessment?

Revenue Streams

- What funding should be use to pay for health reform?
- Should we create a "health assessment fee" on items like tobacco that adversely impact health? What other goods should be assessed?
- What is an appropriate amount for the state to spend on health reform efforts?

Other Questions for the Councils: